Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004964	A. BUILDING: _____ B. WING _____	11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HEALTH NETWORK	3631 N MORRISON RD STE 106 MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS AAAHC Surveyor: 34586 Facility Number: 004964 Type of Survey: State Licensure Off Site AAAHC Accreditation Survey Date of AAAHC On Site Survey - ASC full survey 11/18-19/2014 Date of ISDH off site review - 6/24/15 Reviewer/Surveyor -Kerry Sawin, RN, PHNS Based on review of the 11/18-19/2014 AAAHC Accreditation Survey Report, it has been determined that American Health Network ASC meets the requirements for ASC Licensure in Indiana for 2015.	S 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE